



The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Department of Public Health  
Bureau of Health Professions Licensure  
Board of Registration in Nursing  
Substance Abuse Rehabilitation Program  
250 Washington Street, 3<sup>rd</sup> fl, Boston, MA 02108

CHARLES D. BAKER  
Governor

KARYN E. POLITO  
Lieutenant Governor

MARYLOU SUDDERS  
Secretary

MARGRET R. COOKE  
Acting Commissioner

## FIRST-TIME SARP APPLICATION

If you are seeking **re-admission** into the SARP Program, please complete and return the **RE-ADMISSION APPLICATION**.

Please complete (print):

NAME	
ADDRESS	
TELEPHONE NO.	
EMAIL	

LICENSE NO.	
LICENSE EXP.	
MA COMPLAINT NO. (If you do not have a complaint please write "Self-Referral")	

Please answer all of the following questions:

		YES	NO
1.	Has any disciplinary action ever been taken against you by a professional and/or trade licensing/certification board located in the United States, the District of Columbia, U.S. Territory, or any foreign country/jurisdiction? This also includes any actions taken against your Massachusetts nursing license.		
2.	Are you the subject of pending disciplinary action by a professional and/or trade licensing/certification board located in the United States, the District of Columbia, U.S. Territory, or any foreign country/jurisdiction?		

3.	Have you ever been convicted of a felony or misdemeanor in the United States, the District of Columbia, U.S. Territory, or any foreign country/jurisdiction?		
4.	Are you subject to any pending or open criminal case(s) or investigation(s) in a jurisdiction in the United States, the District of Columbia, or U.S. Territory		
5.	Are you currently enrolled in an alternative to discipline or similar program in a jurisdiction located in the United States, the District of Columbia, or U.S. Territory?		

By applying for admission to the SARP, I admit that I have a substance use disorder. I further admit that my substance use disorder has impaired my competency to practice nursing safely.

I understand that I am responsible for all costs of participation in the SARP, including the admission assessment, enrollment in the Board's designated Drug Testing Management Company (DTMC) for random toxicology screening, and all costs related to counseling and/or therapy.

I understand that a SARP Coordinator will provide me with information regarding the requirements for a substance use disorder assessment, and that within five (5) days of the date of this application I must make an appointment to have a SARP admission assessment completed by a qualified assessor.

I understand that if I am approved for admission to the SARP, my participation in the SARP will remain confidential. In addition, I further acknowledge that I have been informed that any information concerning my substance use disorder obtained during my application and subsequent participation in the SARP will **not** be kept confidential and will be referred to the Board only if I withdraw from, or if I am terminated from the SARP application process or from SARP participation.

I agree that I will not practice as a nurse during the application process and until the SAREC determines that I may safely resume nursing practice. I understand that if I fail to comply, I will be terminated from the SARP application process.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

FOR OFFICE USE ONLY

Date application mailed \_\_\_\_\_

Date Application Expires \_\_\_\_\_

Date completed application and license returned \_\_\_\_\_

Application must be received in the Board office within 30 days of nurse's receipt.